CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/06/2011 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155767		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		NSTRUCTION	(X3) DATE SURVEY COMPLETED 03/04/2011	
	PROVIDER OR SUPPLIER			628 N N	ADDRESS, CITY, STATE, ZIP CODE MERIDIAN ROAD IFIELD, IN46140		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
F0000	State Licensure S Survey dates: Fel & 4, 2011  Facility number: Provider number: AIM number: N Survey team: Angel Tomlinson Sharon Lasher R 2, & 3, 2011] Barbara Gray RN Leslie Parrett RN Census bed type: SNF: 48 Residential: 33 Total: 81  Census payor type Medicare: 23 Other: 58 Total: 81  Sample: 12 Residential samp These deficiencies findings cited in 16.2.	bruary 28, March 1, 2, 3,  005954 :: 155767 IVA  RN TC N [February 28, March 1,  N IV  Dee:  Dee:  Dee:  Dee: 5  Des also reflect state accordance with 410 IAC	F000	00	This Plan of Correction shall serve as the credible allegatic compliance with all state and federal requirements governir the management of this facility. We respectfully reques paper compliance for this Plan Correction.	ng st	(VA) DATE
LABORATOR	Y DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIC	NATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

ZCQJ11

Facility ID:

005954 If continuation sheet

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155767			(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 03/04/2011		
	PROVIDER OR SUPPLIER	AMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 628 N MERIDIAN ROAD GREENFIELD, IN46140					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
	Quality review c Jennie Bartelt, R	ompleted 3/11/11 by N.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155767		A. BI	(X2) MULTIPLE CONSTRUCTION  A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/04/2011	
NAME OF PROVIDER OR S	UPPLIER		B. W	STREET	ADDRESS, CITY, STATE, ZIP CODE MERIDIAN ROAD		
SPRINGHURST HEA					NFIELD, IN46140		
PREFIX (EACH D	EFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F0272 Based or and record to ensure foot was removal podiatris affected related to of 12 (Reference foot podiatris). The cord in an whole the foot right foot foot foot foot foot foot foot fo	observed assess of a cent. The last of the	rvation, interview iew the facility failed and to the resident's sed following allus by the deficient practice residents reviewed and care in a sample at #30).	F	0272	Corrective Actions accomplish for those residents found to he been affected by the alleged deficient practice: Resident's was assessed by the charge nurse during the survey with documentation of assessment included in the resident's reco at that time. Identification of ott residents having the potential be affected by the same alleged deficient practice and correctivactions taken: Residents with wounds and/or "other" skin issewill be audited to ensure assessment and documentation of assessment is complete in resident's record. Measures purinto place and sytemic change made to ensure the alleged deficient practice does not reculticensed nurses will be inserviced on the Other Skin Assessment Guidelines (see Exhibit A). How the corrective measures will be monitored to ensure the alleged deficient practice does not recur: Wee audits of all residents with wounds and/or other skin issue will be conducted to ensure proper assessment and documentation is in place. The audits will be conducted for for weeks to ensure compliance, then conducted randomly and reported through the campus Quality Assurance Committee The Director of Health Service is responsible to ensure compliance.	foot  foot  rd  ner  to  ed  ve  sues  on  the  tt  es  cur:	04/03/2011

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING		COMPLETED	
		155767	B. WIN			03/04/2011	
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE MERIDIAN ROAD		
SPRINGI	HURST HEALTH CA	AMPUS		1	NERIDIAN ROAD NFIELD, IN46140		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE	
	assessment for Resident #30 dated					J.II.Z	
	2-21-11 indica	ated the following: is					
		risk of developing					
	pressure ulcers	s- yes, were pressure					
	ulcers present	prior to admission-					
	no, foot proble	ems- none marked.					
	The "RESIDE"	· ·					
	CONFERENC	CE NOTES," dated					
	2-24-11, indicate	ated there were no					
	areas of skin in	mpairment and the					
	right foot was	being monitored for					
	skin breakdow	n.					
		<b>.</b>					
	-	Examination and					
		te" for Resident #30,					
	dated 12-7-10,						
		n open sore on the					
	_	eatment order was					
	written, and th	e nurse was notified.					
	The note was s	signed by the					
	podiatrist.						
	The December	2010 Modination					
		r 2010 Medication					
		n Record (MAR) for					
	Resident #30 i						
		signed off 12-11-10,					
	12-12-10 and	12-18-10 as					

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		155767	B. WIN			03/04/2011	
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
SPRINGI	HURST HEALTH CA	AMPUS		628 N MERIDIAN ROAD GREENFIELD, IN46140			
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1710	completed, for 3 days of 8 days.			1710			DITE
	•	icated the order was					
		on 12-19-10. The					
		d the weekly skin					
	_	gned for 12-8-10,					
	ŕ	22-10 and 12-29-10					
	indicated no an	reas of skin					
	impairment.						
		D 11					
		Resident #30 dated					
	_	indicated on the					
	weekly skin as	ssessments as no					
	areas of skin ii	mpairment.					
	The MAR for	Resident #30 dated					
	February 2011	indicated the					
	following on t	he weekly skin					
	assessments: 2	2-2-11- no areas of					
	skin impairme	nt, 2-9-11- existing					
	_	ation of location),					
	2-16-11 - no a	,,					
		nd 2-23-11 was not					
	_	an assessment was					
	completed.						
	,						
	   Resident #30's	record indicated no					
	"Other Skin In						
		heet was initiated or					
	Assessment s	meet was initiated of					

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	PROVIDER OR SUPPLIER		B. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE MERIDIAN ROAD FIELD, IN46140		
	SUMMARY S (EACH DEFICIENT REGULATORY OR Completed on the foot ulcer four 12-7-10.  The Podiatry I Treatment Not dated 2-14-11, aspect of the 5 aspect of the foot being treated on the was signed.  During observed 9:10 a.m., Resulted the common at an wheelchair left foot and or right foot. Interest Manager #2 at the facility left the resident be had seen the period of the period	Examination and the for Resident #30, indicated the lateral th metatarsal (outer bot) was dressed and ton the right foot. The tod by the podiatrist.  ation on 3-2-11 at ident #30 was sitting rea of the facility in with a shoe on the right soot on the right shoe off of the cause the resident to the right shoe off of the cause the resident to the right foot.		STREET A	IERIDIAN ROAD	TE	(X5) COMPLETION DATE
	3-3-11 at 9:40	Unit Manager #2 on a.m. requested an Resident #30's right					

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	PROVIDER OR SUPPLIER		628	EET ADDRESS, CITY, STATE, ZIP CO N MERIDIAN ROAD EENFIELD, IN46140	DE		
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	Interview with 3-3-11 at 10:50 had to notify the 3-2-11 because wound on the regulow drainage. The Unit Manareceived a treat resident's right physician todat observation at Director of Nur Resident #30 houter aspect of the right foot, took off the draw dark brown of with a small he surrounding the inflamed. The taken off had a yellow drainage dry and scaly, resident if the the resident incomplete.	y. During this time with ursing (DON) present, had a dressing on the f the middle area of Unit Manager #2 essing and there was colored circle area					

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		199707	B. WIN		DDRESS, CITY, STATE, ZIP CODE	03/04/2	U11
NAME OF F	PROVIDER OR SUPPLIER				MERIDIAN ROAD		
SPRINGI	HURST HEALTH CA	AMPUS		1	FIELD, IN46140		
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TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	DATE
	going to get th	e physician in the	İ				
	building to con	me look at Resident					
	#30's foot. The	e physician indicated					
	to continue wi	th the current					
	treatment and	monitor for					
	improvement.						
	The Change in	Condition form					
		the physician for					
		dated 3-2-11 (no					
		d the resident "had an					
	f *	ne right outer foot					
	_	iatrist removed a					
	_	rogressing very					
	•	pen area measured 1.8					
		cm. There is a small					
		low drainage. May we					
	_	for bacitracin and					
	border gauze a	and change three					
	_	ter cleaning with					
	_	er for 14 days and					
		te the wound." The					
	physician resp	onse dated 3-3-11					
		foam dressing,					
	_	three days and as					
	needed.						
	Interview with	u Unit Manager #2 on					

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	PROVIDER OR SUPPLIER HURST HEALTH CA		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE  IERIDIAN ROAD FIELD, IN46140	l	
					1 ILLD, IN40 140		CV.
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TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	3-3-11 at 11:1:	5 a.m., indicated the					
	weekly skin as	sessments on					
	Resident #30's	Medication					
	Administration	n Record (MAR) had					
	been signed of	f by nurses as no skin					
	impairment. U	nit Manager #2					
	indicated there	e was no skin					
	assessment do	cumentation of the					
	wound except	the one she started					
	on 3-2-11.						
		in Impairment					
		for Resident #30,					
		no time), indicated					
	_	the resident's outer					
	_	ight foot had an 1.8					
	`	n) length by 1.8					
	centimeter wid	Ith and 0.1 centimeter					
	depth area that	t was yellow in color					
	with irregular	wound margins. The					
	area was drain	ing yellow and was					
	painful to touc	h. The area's					
	surrounding tis	ssue was pink.					
		the DON on 3-3-11					
	_	ndicated there was					
	_	ment assessment of					
	Resident #30's	ulcer on the right					

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TAG	foot. The DON nurse or the ur have initiated was identified  The "OTHER ASSESSMEN provided by the 2:10 p.m., indit the purpose was monitor the he impairments of stasis ulcers." document in branche RN/LPN as parpermanent receive completed area and "All recorded in certiform when an identified. Door width, depth, wound margin and tunneling, weekly with comments as recomments "	N indicated the floor nit manager should one when the area on 12-7-11.  SKIN T GUIDELINES" the DON on 3-3-11 at the feated the following: as to "describe and the raining process of skin ther than pressure or the procedure was to lack ink by an first of the resident's ord. The form was to for each impaired measurements are intimeters. Initiate the area of impairment is cument the length, exudate, color, odor, s, surrounding tissue Update the form the	TAG	DEFICIENCY)		DATE

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	treatment and	monitoring."			
	3.1-31(a)				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
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F0282		LSC IDENTIFYING INFORMATION)	F02		Corrective Actions accomplish		
	Based on observation and record		1.02	02	for those residents found to ha		
SS=D		cility failed to follow			been affected by the alleged		
	a physician's o	order for Santyl to a			deficient practice: The resider treatment order was clarified w		
	resident's right	t foot following the			the attending physician during	I	
	removal of a c	allus by the podiatrist			survey, resulting in a new		
	for 1 of 2 resid	lents sampled for			treatment order implemented I	by	
		a total sample of 12			nursing.Identification of other residents having the potential	to	
	(Resident #30)	•			be affected by the same allege		
	(Trestacite 1130)	,-			deficient practice and corrective	I	
r: r: 1 1				actions taken: Residents with wounds and/or "other" skin			
	Findings inclu	de:			issues' charts will be audited to	o	
					ensure physician orders are		
	During observ	ation on 3-1-11 at			properly recorded and		
	2:05 p.m. Resi	dent #30 was sitting			documented by licensed nurse Measures put into place and	es.	
	in the commor	n area of the facility			systemic changes made to		
	in an wheelcha	air with a shoe on the			ensure the alleged deficient	.	
		nly a sock on the			practice does not recur: Licen nurses will be inserviced on the	• • • • • • • • • • • • • • • • • • •	
	right foot.	ing a socia on the			Specific Medication		
	right 100t.				Administration Procedures (se	I	
	D : 0.1	1 CD :1			Exhibit B) to ensure physician		
		record of Resident			orders are properly recorded a documented. How the correct		
	#30 on 3-1-11	at 2:10 p.m.,			measures will be monitored to		
	indicated the r	esident's diagnoses			ensure the alleged deficient	Lib.	
	included, but v	were not limited to,			practice does not recur: Weel audits, conducted five times	KIY	
	Alzheimer den	nentia, depression,			weekly for four weeks, will rev	iew	
		deaf, blind in the			residents with wounds and/or		
	•	heumatoid arthritis.			"other" skin issues' documentation to ensure		
		monimum artificity.			compliance. After four weeks	the	
	The Minimum	Data Cat (MDC)			audits will be conducted rando	omly	
		Data Set (MDS)			and reported through the cam		
	assessment for	Resident #30, dated			Quality Assurance committee. The Director of Health Service	• • • • • • • • • • • • • • • • • • •	
					,		
	<u> </u>						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155767		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPLETED  03/04/2011		
		100707	B. WII			03/04/2	.011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
SPRING	HURST HEALTH CA			GREEN	MERIDIAN ROAD IFIELD, IN46140		
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	2-21-11, indica	ated the following:			responsible to ensure		
	making self ur	•			compliance.		
	understood, ab	oility to understand					
	others-someting	nes understands,					
	transfer- exten	sive assistance of one					
	person, bathing	g-total dependence,					
	mobility devic	es- wheelchair, is the					
	resident at risk	of developing					
	pressure ulcers	s- yes, were pressure					
	ulcers present	prior to admission-					
	no, foot proble	ems- none marked.					
	The "Podiatry Examination and Treatment Note" for Resident #30, dated 12-7-10, indicated the resident had an open sore on the						
	right foot, a tre	eatment order was					
	written and the	e nurse was notified.					
	The note was s	signed by the					
	podiatrist.						
	#30, dated 12- rinse the ulcers of the 5th meta aspect of the u and the 5th me	order for Resident 7-10, indicated to s on the lateral aspect atarsal head (outer pper part of the foot) etatarsal base (outer hiddle part of the					

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION		(X3) DATE COMPL	
		155767	A. BUII				03/04/2	
			B. WIN		DDRESS, CITY, STATE, Z	IP CODE	L	
NAME OF I	PROVIDER OR SUPPLIER				ERIDIAN ROAD	л СОВЕ		
SPRING	HURST HEALTH CA				FIELD, IN46140			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN O			(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	THE APPROPRIAT	TE	COMPLETION DATE
		ght foot once a day						_
	l '	aline solution and						
	then apply Santyl (debridement							
	medication that digests necrotic							
	tissue) and cov	ver with Kerlix. The						
	resident was n	ot to wear the right						
	shoe until heal	led. The physician						
	order was sign	ed by the podiatrist.						
		r 2010 Medication						
		n Record (MAR) for						
		ndicated the Santyl						
		signed off 12-11-10,						
	12-12-10 and							
	_	3 days of 8 days.						
	The MAR indi	icated the order was						
	discontinued o	on 12-19-10. The						
		d the weekly skin						
	l –	gned for 12-8-10,						
	12-15-10, 12-2	22-10 and 12-29-10						
	indicated no a	reas of skin						
	impairment.							
	TT1 1	. 1 1 1 0						
	1 * *	telephone order for						
	· ·	dated 12-19-10 (no						
	·	d to discontinue the						
	1	ent to the right foot						
	and continue to	o leave off the right						
FORM CMS-2	2567(02-99) Previous Versio	ons Obsolete Event ID:	ZCQJ11	Facility II	D: <b>005954</b>	If continuation s	heet Pa	ge 14 of 36

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  155767			(X2) MULTIPLE CC  A. BUILDING  B. WING	ONSTRUCTION	(X3) DATE COMP 03/04/2	LETED
	PROVIDER OR SUPPLIER		628 N N	ADDRESS, CITY, STATE, ZIP CODI MERIDIAN ROAD NFIELD, IN46140	E	
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	shoe. The resident indicate an ass	dent's record did not sessment related to the Santyl treatment.				

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			D. ((1)		ADDRESS, CITY, STATE, ZIP CODE		
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PREFIX	· ·	CY MUST BE PERCEDED BY FULL	CROS		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0309	Based on obse	rvation, interview	F03	09	Corrective Actions accomplish for those residents found to ha		04/03/2011
SS=D		iew the facility failed			been affected by the alleged		
	to assess and t	reat a resident's right			deficient practice: Resident's		
	foot following	removal of a callus			was assessed during the surve by the charge nurse with	еу	
	_	st. The deficient			documentation of assessment		
	-				included in the resident's		
	-	ed 1 of 2 residents			record.Identification of other		
		yound care in a total			residents having the potential		
	sample of 12 (	Resident #30).			be affected by the same allege		
					deficient practice and corrective actions taken: Residents with	/E	
	Findings inclu	de:			wounds and/or "other" skin iss	ues	
	i mamgs mera	de.			will be audited to ensure prope	er	
					assessment and documentation	n	
	During observ	ation on 3-1-11 at			is present.Measures put into		
	2:05 p.m., Res	ident #30 was sitting			place and systemic changes made to ensure the alleged		
	_	n area of the facility			deficient practice does not rec	ur:	
		air with a shoe on the			Licensed nurses will be		
					inserviced on Other Skin		
		nly a sock on the			Assessment Guidelines (Exhib		
	right foot.				A). How the corrective measure will be monitored to ensure the		
					alleged deficient practice does		
	Review of the	record of Resident			not recur: Weekly audits of		
	#30 on 3-1-11				resident with wounds and/or		
		_			"other" skin issues will be		
		esident's diagnoses			conducted for four weeks to determine ongoing compliane.		
	included, but v	were not limited to,			After four weeks audits will be		
	Alzheimer der	nentia, depression,			conducted randomly and repo	rted	
		deaf, blind in the			through campus Quality		
	· ·	heumatoid arthritis.			Assurance committee. The		
		neumatora artifitis.			Director of Health Services is responsible to ensure		
					compliance.		
	The Minimum	Data Set (MDS)			,		
	assessment for	Resident #30, dated					
	1		1		l		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155767		A. BUII	LDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 03/04/2011		
	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE MERIDIAN ROAD FIELD, IN46140		
	SUMMARY S (EACH DEFICIENT REGULATORY OR 2-21-11, indicated an interest on 12-28-10 of foot.  HURST HEALTH CASUMMARY S (EACH DEFICIENT REGULATORY OR 2-21-11, indicated an interest on the resonant resonant resonant resonant resident at risk pressure ulcers ulcers present no, foot problem on 12-28-10 of foot.  The assistance care plan for R indicated an interest of resident resident resident resident resident resident resident at risk pressure ulcers present no, foot problem resident res	AMPUS  TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  Ated the following: Inderstood- Indirection in the sunderstands, sive assistance of one g-total dependence, es- wheelchair, is the stof developing s - yes, were pressure prior to admission - Indirection in comfort (arthritis) Itesident #30 Itervention was added If no shoe on the right  NT FIRST		628 N M	MERIDIAN ROAD	ATE	(X5) COMPLETION DATE
	2-24-11, indica	TE NOTES," dated attention attention attention attention and the attention a					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155767		(X2) MULTIPLE CO  A. BUILDING  B. WING	NSTRUCTION	COMI	(X3) DATE SURVEY COMPLETED 03/04/2011	
	PROVIDER OR SUPPLIER		628 N N	ADDRESS, CITY, STATE, ZIP CODE MERIDIAN ROAD IFIELD, IN46140	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	) BE	(X5) COMPLETION DATE
	right foot was skin breakdow	being monitored for vn.				
	Treatment Not dated 12-7-10, resident had an right foot, and the nurse was was signed by  The physician #30, dated 12-rinse the ulcer of the 5th meta aspect of the ulcer aspect of the ulcer of the 5th meta aspect of the right with normal satthen apply Sar medication that tissue) and corresident was no shoe until the	n open sore on the order was written and notified. The note				

005954

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155767			A. BUI	LDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 03/04/2011	
		100707	B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE	03/04/2	V11
NAME OF I	PROVIDER OR SUPPLIER				MERIDIAN ROAD		
	HURST HEALTH CA			GREEN	IFIELD, IN46140		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TΕ	DATE
	The December	2010 Medication					
	Administration Record (MAR) for						
	Resident #30 i	ndicated the Santyl					
	treatment was	signed off as					
	completed on	12-11-10, 12-12-10					
	and 12-18-10,	for 3 days of 8 days.					
	The MAR indi	icated the order was					
	discontinued o	on 12-19-10. The					
	MAR indicate	d the weekly skin					
	assessment sig	gned for 12-8-10,					
	12-15-10, 12-2	22-10 and 12-29-10					
	indicated no ar	reas of skin					
	impairment.						
	The physician	telephone order for					
		dated 12-19-10 (no					
	· ·	d to discontinue the					
	Í	ent to the right foot					
	· -	o leave off the right					
		dent's record did not					
		sessment related to					
		n of the Santyl					
	treatment.	n or the Santyi					
	deamicht.						
	The MAR for	Resident #30, dated					
		indicated on the					
	•	ssessments as no					
	areas of skin ii						
		r					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155767		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION	(X3) DATE SURVEY COMPLETED 03/04/2011		
	ROVIDER OR SUPPLIER		p. WINC	STREET A	ADDRESS, CITY, STATE, ZIP CODE MERIDIAN ROAD IFIELD, IN46140	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN) REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)  Resident #30, dated		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΛΤΕ	(X5) COMPLETION DATE
	February 2011 weekly skin as following: 2-2 impairment, 2-(no indication - no areas of sl 2-23-11 was no assessment was Resident #30's "Other Skin In Assessment" s completed on the foot ulcer four 12-7-10.  The Podiatry For Treatment Not dated 2-14-11, aspect of the 5 aspect of the following interviews 3/3/11 at 12:05	, indicated on the sessments the -11- no areas of skin -9-11- existing area of location), 2-16-11 kin impairment, and ot signed off that an is completed.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155767	B. WIN			03/04/2	011
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
SDDING	HURST HEALTH CA	VMDITE		1	MERIDIAN ROAD IFIELD, IN46140		
					171ELD, 11140140		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	for the residen	t. The DON					
	indicated the F	Podiatrist said he					
	didn't assess th	ne resident's wound					
	on 2/14/11 was	s because it had a					
	dressing on it.						
	During observ	ation on 3-2-11 at					
	_	ident #30 was sitting					
	the common a	rea of the facility in					
		with a shoe on the					
	left foot and or	nly a sock on the					
		rview with Unit					
	_	this time indicated					
	_	t the right shoe off of					
	_	ecause the resident					
		odiatrist and he had					
	_	lus on the right foot					
	and a shoe bot						
	and a snoc bot	nord it.					
	During intervi	ew with Unit					
		1 3-3-11 at 9:40 a.m.,					
	_	of Resident #30's					
	right foot was						
	rigiii ioot was	requesteu.					
	   Interview with	Unit Manager #2 on					
		0 a.m., indicated she					
		he physician on					
	•						
	5-2-11, Decaus	se Resident #30 had a					

	OF CORRECTION	IDENTIFICATION NUMBER:			NSTRUCTION		(X3) DATE SURVEY  COMPLETED	
		155767	A. BUI B. WIN	LDING IG			03/04/2011	
NAME OF I	PROVIDER OR SUPPLIER		P. ", II'	_	DDRESS, CITY, STA	ΓE, ZIP CODE	<u> </u>	
				1	IERIDIAN ROAD			
	HURST HEALTH C			<u>.                                    </u>	FIELD, IN46140			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL		ID PREFIX		AN OF CORRECTION E ACTION SHOULD BE		(X5) COMPLETION
TAG	•	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCE	D TO THE APPROPRIATION (CIENCY)	ΓE	DATE
	wound on the	right foot and it had						
	yellow drainag	ge coming from it.						
	The Unit Man	ager #2 indicated she						
	received a treatment order for the							
	resident's right	t foot from the						
	physician toda	y. During						
	observation at	this time with						
	Director of Nu	rsing (DON) present,						
	Resident #30 l	nad a dressing on the						
	outer aspect of	f the middle area of						
	the right foot.	Unit Manager #2						
	took off the dr	essing, and there was						
	a dark brown o	colored circle area						
	with a small h	ole in it, the						
	surrounding ti	ssue was red and						
	inflamed. The	dressing that was						
	taken off had a	a small amount of						
	yellow drainag	ge. The right foot was						
	dry and scaly.	The DON asked the						
	resident if the	right foot hurt and						
	the resident in	dicated that it did						
	hurt. The DON	N indicated she was						
	going to get th	e physician in the						
	building to con	me look at Resident						
	_	e physician came in						
		room and queried						
		nd of treatment was						
	being done for	the resident's right						
FORM CMS-2	567(02-99) Previous Versio	ons Obsolete Event ID:	ZCQJ11	Facility I	D: 005954	If continuation s	heet Pa	ge 22 of 36

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155767		A. BUIL	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED 03/04/2011	
		100707	B. WING		ADDRESS, CITY, STATE, ZIP CODE	03/04/2	011
NAME OF F	PROVIDER OR SUPPLIER				MERIDIAN ROAD		
SPRING	HURST HEALTH CA	AMPUS		GREEN	IFIELD, IN46140		
(X4) ID		TATEMENT OF DEFICIENCIES	┰	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	πE	COMPLETION DATE
	foot. The Unit						2.112
		ptifoam dressing was					
	being done and the resident was						
	_	mnicef (antibiotic)					
	•	tract infection. The					
		cated to continue					
	with the currer	nt treatment and					
	monitor for im	provement.					
	The change in	condition form					
	notification to	the physician for					
	Resident #30,	dated 3-2-11 (no					
	time), indicate	d the resident had an					
	"open area to t	the right outer foot					
	where the pod	iatrist removed a					
	callus that is p	rogressing very					
		oen area measured 1.8					
		cm. There is a small					
		ow drainage. May we					
		for Bacitracin and					
	_	and change three					
	-	ter cleaning with					
		er for 14 days and					
		te the wound." The					
		onse dated 3-3-11					
		c foam dressing,					
		three days and as					
	needed.						

005954

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155767	B. WIN			03/04/2	011
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
SPRING	HURST HEALTH CA	AMPUS		1	/IERIDIAN ROAD IFIELD, IN46140		
(X4) ID		TATEMENT OF DEFICIENCIES	_	ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	· E	DATE
TAG	Interview with 3-3-11 at 11:15 weekly skin as Resident #30's Administration been signed of impairment. U indicated there assessment downed except 3-2-11.  The "Other Sk Assessment" for dated 3-2-11 (to the following: aspect of the ricentimeter (cm.)	Unit Manager #2 on 5 a.m., indicated the seessments on Medication in Record (MAR) had if by nurses as no skin init Manager #2 was no skin cumentation of the the on she started on in Impairment for Resident #30, no time), indicated the resident's outer light foot had an 1.8 in length by 1.8		TAG			DATE
	depth area that with irregular area was drain painful to touc						
		the DON on 3-3-11 indicated there was					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155767	A. BUI	A. BUILDING			COMPLETED 03/04/2011	
		155767	B. WIN		PROPERTY OF THE CORP.	03/04/20	711	
NAME OF I	PROVIDER OR SUPPLIEF	R		1	ADDRESS, CITY, STATE, ZIP CODE MERIDIAN ROAD			
	HURST HEALTH C	AMPUS		GREEN	IFIELD, IN46140			
(X4) ID		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	`	LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE	
	no skin impaii	ment assessment of						
	Resident #30's	s ulcer on the right						
	foot. The DO	N indicated the floor						
	nurse or the u	nit manager should						
	have initiated	one when the area						
	was identified	on 12-7-10.						
	Review of the	"OTHER SKIN						
	ASSESSMENT GUIDELINES"							
	provided by the DON on 3-3-11 at							
	2:10 p.m., indicated the following:							
	the purpose w	as to "describe and						
	monitor the he	ealing process of skin						
	impairments of	other than pressure or						
	stasis ulcers."	The procedure was to						
	document in b	lack ink by an						
	RN/LPN as pa	art of the residents						
	permanent rec	ord. The form is to be						
	completed for	each impaired area.						
	_	nents are recorded in						
	centimeters. In	nitiate the form when						
	an area of imp	pairment is identified.						
	1	length, width, depth,						
	exudate, color	, odor, wound						
		ounding tissue and						
	tunneling. Up	date the form weekly						
	with current tr	reatment, medical						
	interventions a	and comments as						

005954

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155767	(X2) MULTIPLE CC  A. BUILDING  B. WING	NSTRUCTION	COM	(X3) DATE SURVEY COMPLETED 03/04/2011	
	PROVIDER OR SUPPLIER		628 N N	ADDRESS, CITY, STATE, ZIP COD MERIDIAN ROAD NFIELD, IN46140	E		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
TAG	needed. Note '	healed' when the ger requires treatment	TAG	DEFICIENCY)		DATE	

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SU COMPLE	
		155767	1			03/04/20	11
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				MERIDIAN ROAD		
SPRINGI	HURST HEALTH CA	AMPUS			NFIELD, IN46140		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0323		rvation, interview	F03	23	Corrective Actions accomplish for those residents found to ha		04/03/2011
SS=D	and record rev	iew, the facility			been affected by the alleged		
	failed to provi	de interventions to			deficient practice: Resident's		
	prevent injury	from falls for 1 of 6			personal alarm was added to he recliner chair during the survey		
	residents revie	wed for falls in a			and staff reminded to ensure of		
		(Resident #10)			light was available at all		
	sample of 12.	(Resident #10)			times.Identification of other		
	TO: 1: . 1	1			residents having the potential be affected by the same allege		
	Findings inclu	de:			deficient practice and corrective		
					actions taken: Residents with		
	Resident #10's	record was reviewed			personal alarms will be audited	d to	
	on 2/28/11 at 1	12:20 p.m. Resident			ensure placement of alarm		
		es included, but were			according to their plan of care. Measures put into place a	and	
	_				systemic changes made to		
	•	osteoporosis and left			ensure the alleged deficient		
	arm fracture.				practice does not recur: Licen		
					nurses wil be inserviced on the Falls Management Program	9	
	Resident #10's	"Care Area			Guidelines (Exhibit C) to ensur	re	
	Assessment" d	lated 2/21/11			implementation of personal		
		s on our assisted			alarms is consistent in		
					documentation in plan of care,		
	_	en more debility			nursing assignment sheet, and actual implementation for resid		
	noted/fell fract	tured left wrist and			safety. How the corrective		
	went to (local)	hospital). Was			measures will be monitored to		
	admitted to he	alth care side related			ensure the alleged deficient		
	to fracture/deb				pratice does not recur: Five randomly selected residents w	,iII	
		inty.			be audited weekly for four week		
		4 75' 2			to ensure compliance with		
		the Director of			personal alarm placement in		
	Nursing (DON	I) on 2/28/11 at 1:15			accordance with resident's pla care and nursing assignment	n of	
	p.m., indicated	l Resident #10 was			sheet. After four weeks, rando	om	
	_	living side of the			audits will be conducted and		
	on the appleted				reported through campus Qua	lity	

	IT OF DEFICIENCIES OF CORRECTION			LDING	NSTRUCTION	(X3) DATE: COMPL 03/04/2	ETED
	PROVIDER OR SUPPLIER		p. wiiv	STREET A	ADDRESS, CITY, STATE, ZIP CODE MERIDIAN ROAD NFIELD, IN46140	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤΕ	(X5) COMPLETION DATE
IAU	facility when so on 2/5/11 and hospital. The she was discharated to the falls and her dadmitted to the facility.  On 2/28/11 at #10 was obserther recliner chair.  On 3/2/11 at 1 #10 was sitting recliner chair, and in reach.  Interview with 3/2/11 at 1:20 resident does the facility with and in her when the facility with the facility wi	the fractured her arm was sent to the DON indicated when arged from the 3/11, due to multiple ecline, she was a health care side of 1:10 p.m., Resident wed sitting upright in air without an alarm 0:30 a.m., Resident gupright in her without an alarm in her call light was not 1:10 p.m., indicated the not have an alarm in last when she is in bed		IAU	Assurane committee. The Director of Health Services is responsible to ensure compliance.		DATE

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING			COMPI	LETED
		155767	B. WIN	G		03/04/2	011
NAME OF I	PROVIDER OR SUPPLIEI	₹		1	DDRESS, CITY, STATE, ZIP CODE		
SPRING	HURST HEALTH C	AMPUS		1	IERIDIAN ROAD FIELD, IN46140		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	l '	NCY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
	indicated the			_			
		xpress ideas and					
	wants, unders	-					
	- ability to und	derstand others,					
	understands						
	- short term m	emory, memory					
	problem						
	- transfer, exte	ensive assistance with					
	two persons physical assist						
	- walk in room, extensive						
	assistance, with two person						
	physical assist						
	- walk in corri	idor, activity did not					
	occur						
		ent have a fall any					
		t month prior to					
	admission, ye						
		ent have a fall any					
		t 2-6 months prior to					
	admission, ye						
		ent have any fracture					
		ll in the 6 months					
	prior to admis	sion, yes."					
	Resident #104	s "Fall Circumstance,					
		nd Intervention"					
	l	following falls prior					
	to admission t						
	to admission (	o the facility.					

STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER  628 N MERIDIAN ROAD  SPRINGHURST HEALTH CAMPUS  GREENFIELD, IN46140	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION  PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG DEFICIENCY	(X5) COMPLETION DATE
"- 1/19/11 at 6:20 p.m., leaning over to pick up object off of floor lost balance - 1/24/11 at 3:30 p.m., resident was found sitting on floor on buttocks - 2/3/11 at 12:15 a.m., (location of fall not on circumstance assessment) - 2/5/11 at 11:35 p.m., (location of fall not on circumstance assessment)."  Resident #10's x-ray of left wrist dated 2/6/11 indicated fractures of the left wrist.  Resident #10's care plan dated 2/21/11, indicated "problems at risk for fall/injury history of falls potential for fall, fractured left wrist. Goal, resident will have reduced risk of fall related injury by utilizing fall precautions. Interventions include but are not limited to, call light in reach provide/monitor use of adaptive devices, wheelchair. Intervention added 2/9/11, bed/chair alarms."	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155767		(X2) MULTIPLE CC	UNSTRUCTION	COMP 03/04/2	LETED	
		155707	B. WING	ADDRESS STEEL ST.		
NAME OF I	PROVIDER OR SUPPLIER		l l	ADDRESS, CITY, STATE, ZIP CODE MERIDIAN ROAD		
SPRING	HURST HEALTH CA	AMPUS	l l	NFIELD, IN46140		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL		
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPR DEFICIENCY)		COMPLETION DATE
	Resident #10's recapitulation indicated device Interview with at 10:00 a.m. r #10's falls indicated 2/3/11 was frought the fall on 2/5/2 chair in her roce	s physician orders dated 3/1/11, ces: chair alarm.  In the DON on 3/3/11 regarding Resident facted the fall on m her recliner, and 1/11 was from her om. She also dent #10 has an alarm				

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155767	B. WIN			03/04/20	)11
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			628 N N	MERIDIAN ROAD		
	HURST HEALTH CA	AMPUS	_	GREEN	NFIELD, IN46140		
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF			
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		TΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
F0371	Based on obse	rvation, and	F03	/1	Corrective Actions accomplish for those residents found to ha		04/03/2011
SS=F	interview and record review, the				been affected by the alleged		
	facility failed t	to label and date			deficient practice: The unmark		
	opened, and co	ooked foods placed in			food items were removed from	ו	
	_	and freezer in the			the walk-in freezer and refrigerator during the		
	_				walk-through with the surveyo	r.	
	· ·	niled to monitor and			Two new sanitizing buckets we	ere	
		sanitation buckets at			prepared after the walk-throug	ıh	
	appropriate pa	rts per million in the			with the surveyor and tested	.	
	kitchen. This practice had the potential to affect 48 of 48 residents who are served their meals from the				appropriately. Identification of other residents having the		
					potential to be affected by the		
					same alleged deficient practice	e	
					and corrective actions taken:		
	kitchen.				Director of Food Services aud		
					both walk-ins and reach-ins to ensure all items properly		
	Findings inclu	de:			identified and dated at conclus	sion	
	i mamgs mera	<b>.</b>			of walk-through with surveyor,		
		0.1 0 11:			addition to preparing new		
	An initial tour	•			sanitizing solutions and record		
	kitchen was co	onducted on 2/28/11			their PPM. Measures put into place and systemic changes		
	at 11:18 A.M.,	with the Director of			made to ensure the alleged		
	· ·	, and the following			deficient practice does not rec	ur:	
	· ·	•			Dietary staff inserviced on poli	су	
		The walk in freezer			for Leftover Foods (Exhibit D),		
	contained the	following foods that			addition to preparing, testing a	and	
	had been open	ed or cooked with no			documenting the PPM for the sanitizing buckets and		
	label or open d	late placed on the			3-compartment sink. How the		
	•	container: a plastic			corrective measures will be		
		-			monitored to ensure the allege		
		ooked vegetable soup,			deficient practice does not rec	ur:	
	a plastic conta	iner of cooked green			Director of Food Services, Assistant Director, and Cooks	are	
	beans, a liter o	of diet coke, a			responsible to monitor on a da		
		onal box of 4 fudge			basis to ensure leftover foods		
	1001delit 5 pers	ona			labeled and dated appropriate	ly,	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	155767	1	LDING		03/04/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER				MERIDIAN ROAD		
SPRING	HURST HEALTH CA	AMPUS		GREEN	NFIELD, IN46140		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE	
		lents personal boxes			in addition to ensuring proper		
	· ·	large containers of			preparation and documentatio sanitizing buckets and	n of	
		ag of onion rings, a			3-compartment sink. Director	will	
	bag of hashbro	-			report findings through the campus Quality Assurance		
	cheesecake co	ntaining 7 slices, and			committee monthly. Director of	of	
		f strawberries. The			Food Services maintains over responsibility for compliance.	all	
	walk in refrige	erator had a box			responsibility for compliance.		
	containing 35	mighty shakes.					
	Instructions on the mighty shakes indicated to store frozen - thaw at						
	or below 40 degrees. Use thawed						
	product within	14 days. Keep					
	refrigerated. A	An interview with the					
	Director of Fo	od Services indicated					
	the items were	not labeled or dated.					
	At 11:25 A.M.	, 2 buckets used to					
	clean in the kit	tchen were tested for					
	chemical sanit	izer. Both cleaning					
	buckets tested	read 0 parts per					
	million (ppm).	The Hydro Sink					
	Master attache	ed to the sink faucet,					
	that dispensed	the chemical					
	sanitizer was t	ested and read 400					
	ppm. An inter	view with the					
	Director of Fo	od Services indicated					
	both buckets to	ested 0 ppm, and the					
	sink tested at 4	100 ppm. The same 2					
					<u> </u>		

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		NSTRUCTION	(X3) DATE SURVEY  COMPLETED  02/04/2011	
		155767	B. WIN			03/04/2011	
	PROVIDER OR SUPPLIER			628 N N	ADDRESS, CITY, STATE, ZIP CODE MERIDIAN ROAD		
SPRING	HURST HEALTH CA	AMPUS		GREEN	IFIELD, IN46140		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	buckets were r	re-tested for chemical					
	sanitizer at 11:	55 A.M. Both					
		parts per million. A					
		f chemical sanitizer					
	_	into a bucket from					
	<i>'</i>	ne chemical sanitizer					
	* *	n. An interview with					
		Food Services					
		puckets read 0 ppm,					
		hanged yet, and the					
	sink sanitizer tested 400 ppm. The						
	Director of Food Services indicated						
		th chemical sanitizer					
		nged approximately					
	-	tes to 1 hour. The					
		od Services indicated					
		anitation for the					
	buckets and sin	nk should be 200					
	ppm. The Dire						
		ated the buckets and					
	sink should be	tested for chemical					
	_	to each meal and					
	documented.	A review of the					
		vashing (3 - bay sink)					
		record indicated the					
	sink, and buck	et chemical sanitizer					
	had been tested	d and documented for					
	one supper me	al on 2/19/11. No					

Facility ID:

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155767	(X2) MULTIPLE CC A. BUILDING B. WING	NSTRUCTION	(X3) DATE COMP 03/04/2	LETED
	PROVIDER OR SUPPLIER	AMPUS	STREET A 628 N N	ADDRESS, CITY, STATE, ZIP CODE MERIDIAN ROAD NFIELD, IN46140		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	) BE	(X5) COMPLETION DATE
		I sanitation tests were or February, 2011.				
	An interview of Food Services A.M., indicate served their management of the Handling of Laprovided by the on 3/1/11 at 9: the following: foods will be appropriate and in controlling 2.) "Leftovers dated, labeled, soon as meal second to belowithin 2 hours degrees within "Refrigerated used within 72.	with The Director of on 3/4/11 at 10:15 and all residents are eals from the kitchen.  most current eftover Food policy the Executive Director 30 A.M., indicated Policy - "Leftover attilized in an disafe manner to aid to waste." Procedure - a should be covered, and refrigerated as the service is finished and to wor at 70 degrees and below or at 41				
	which are froz that they are a	en are covered so ir-tight and moisture are labeled with item				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  155767			A. BUILDING COMP			(X3) DATE : COMPL 03/04/2	ETED
	PROVIDER OR SUPPLIER		1	STREET A	DDRESS, CITY, STATE, ZIP CODE MERIDIAN ROAD FIELD, IN46140	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
ı	and date." 8) cooking are av are leftover an "The Dining S Cook checks f				CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	